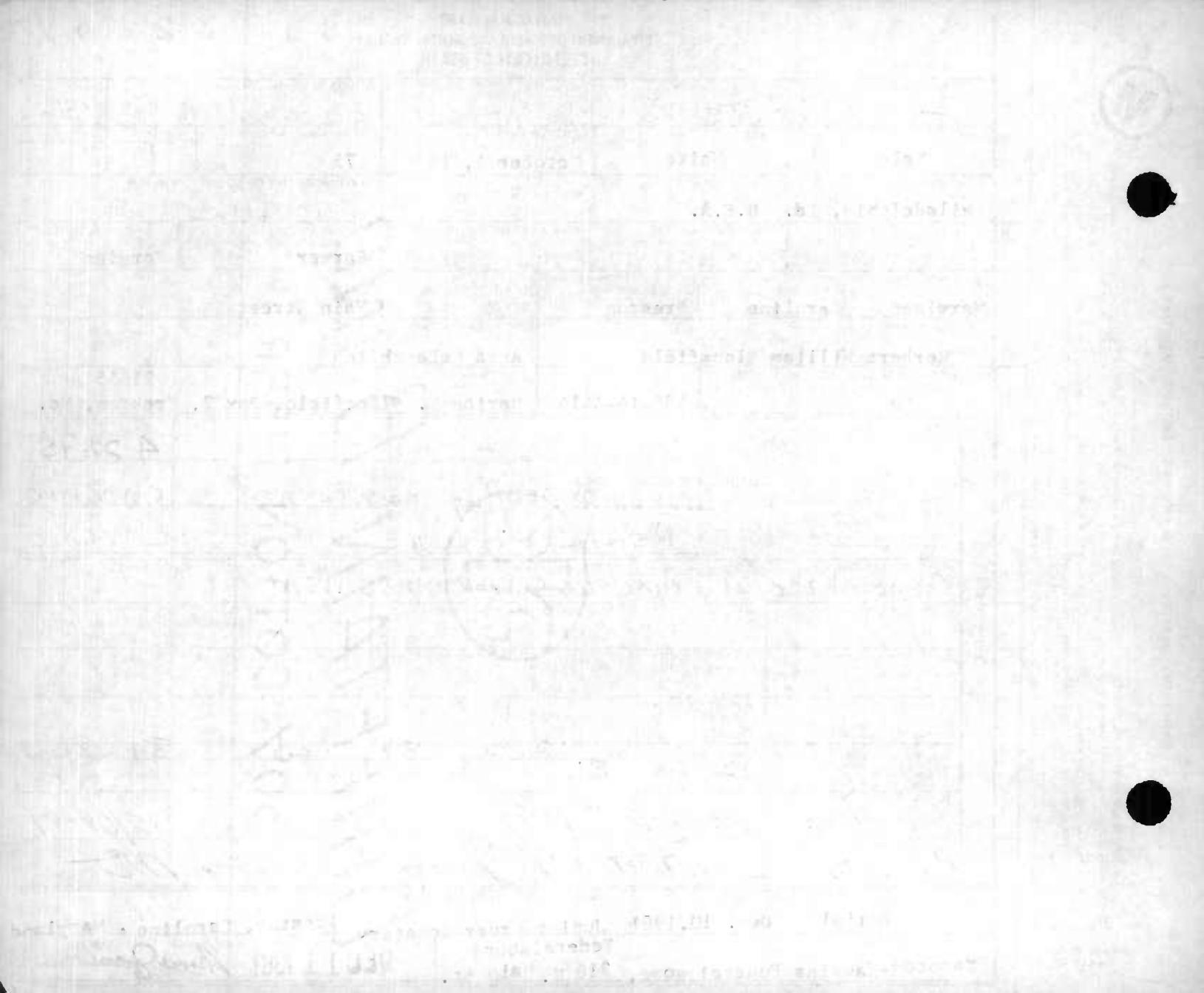


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 3 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 3 2 1 8 1				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
H. Chester						Bloomfield			December			8	1981	1:50 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			MONTH DAY YEAR October 4, 1906			75			MONTHS		DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Philadelphia, Pa.			U.S.A.						Caroline							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Denton			Caroline Nursing Home			Farmer			Farming							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Maryland			Caroline			Preston			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Main Street				
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME										
Herbert William Bloomfield						Anna McLaughlin										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			21655				
No			188-14-4414			Marion W. Bloomfield, Box 2, Preston, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
5850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												4 DAYS				
(b) DUE TO, OR AS A CONSEQUENCE OF GENERALIZED DEBILITY and weakness												chronic				
(c) DUE TO, OR AS A CONSEQUENCE OF RENAL FAILURE												chronic				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized arteriosclerosis, Parkinsonism																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 12/3/81 to 12/8/81, that (I) (we) last saw the deceased alive on 12/6/81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did) not view the body after death.																
22b. SIGNATURE			DEGREE			22c. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED							
Christian E. Jensen MD									Christian E. Jensen MD			12/08/81				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS													
Christian E. JENSEN MD																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial			Dec. 10, 1981			Junior Order Cemetery			Preston, Caroline, Maryland							
24. FUNERAL DIRECTOR NAME			ADDRESS			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE							
Frampton-Hawkins Funeral home,			216 N. Main St.						DEC 11 1981			Helen Jean Norton				

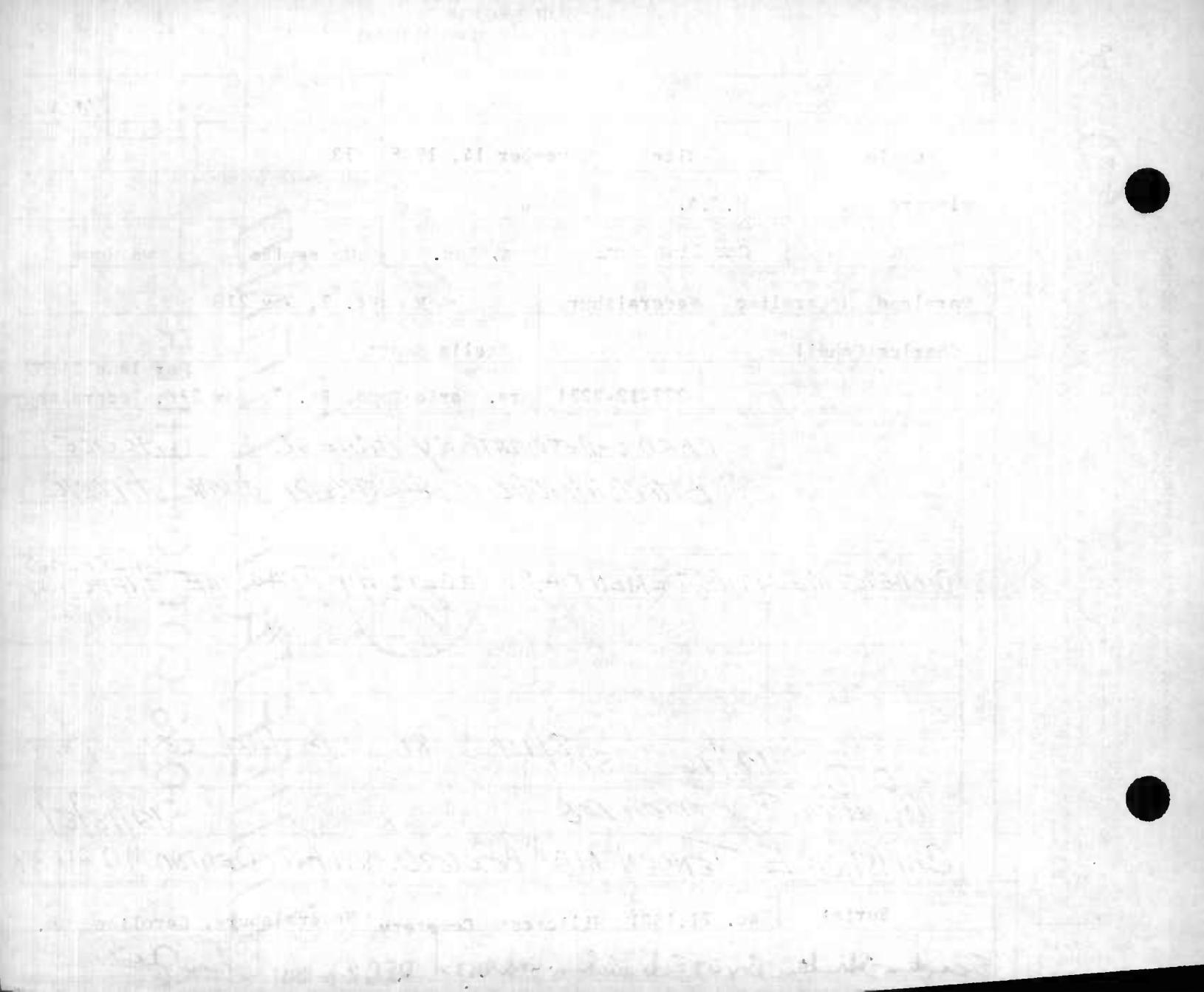


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8132188						
											REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	26. HOUR			
Florence						Elderdice			12 18 81						10:00A M			
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH NOVEMBER DAY 14, YEAR 1908			6. AGE (IN YEARS LAST BIRTHDAY) 73			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Caroline			YRS.		MIN.				
10. CITY OR TOWN OF DEATH Denton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Caroline Nursing Home, Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home			MD.						
13a. STATE Maryland			13b. COUNTY Caroline			13c. CITY OR TOWN Federalsburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 2, Box 218						
14. FATHER'S NAME FIRST MIDDLE LAST Charles Cahall						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Scott												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 222-12-2221			17. INFORMANT Mrs. Marie Todd, Rt. 2, Box 218, Federalsburg			ADDRESS Maryland 21632									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> chronic												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE						
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>DIABETES MELLITUS, DEMENTIA, S/P RECENT HIP FRACTURE, INFECTION</u>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12/16/81 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												12/18/81						
22b. SIGNATURE <u>Christian E. Jensen MD</u>			22c. DEGREE DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12/18/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christian E. JENSEN MD			22e. ADDRESS Box 690, Kerr Ave, Denton MD 21629															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 21, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery			23d. LOCATION CITY OR TOWN Federalsburg, Caroline, Md.									
24. FUNERAL DIRECTOR NAME Frances - Hawkins, Box 43 Federalsburg, MD 21632			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 23 1981			25b. REGISTRAR'S SIGNATURE <u>James J. Hansen</u>									

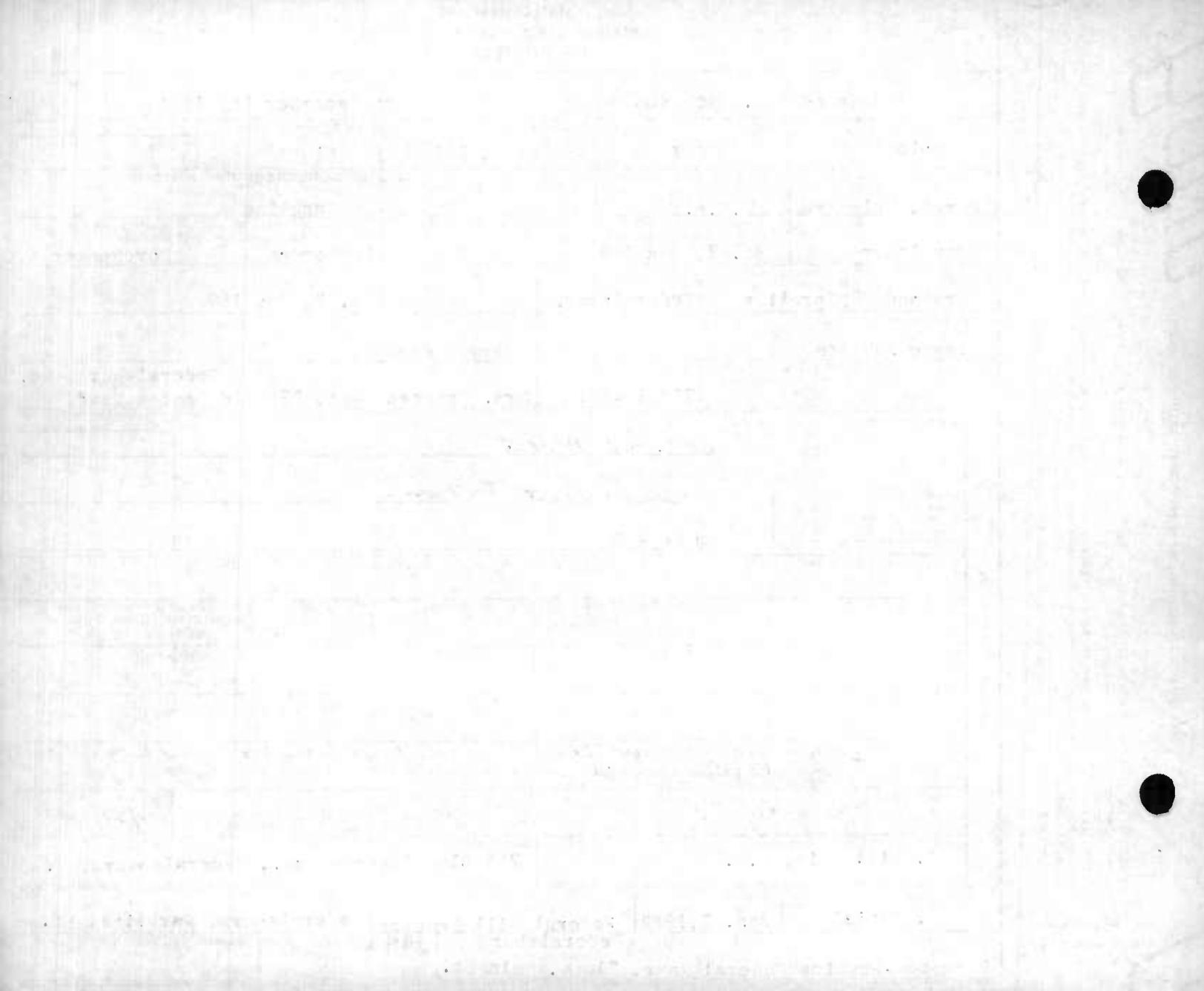


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8132189								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Ernest L. Johnson												December 26, 1981			A.				M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)						IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			Negro			MONTH DAY YEAR August 8, 1920			61						MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH											
Laurel, Delaware			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Caroline											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Federalsburg			Rt. 2, Box 169			Lumberman			Dorchester L.C.											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Maryland			Caroline			Federalsburg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 2, Box 169								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
Isaac Johnson									Mary Anderson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes			WWII			213-18-5819A			Mrs. Frances Hunt, 220 Old Denton Road,											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4292			DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/34/1929 to 12/23/1981, that (I) (we) last saw the deceased alive on 12/23/1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE S. Willy Lin.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/28/81											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Willy Lin, M.D.			22e. ADDRESS 215 Bloomingdale Ave., Federalsburg, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 2, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Federal Hill Cemetery			23d. LOCATION CITY OR TOWN Federalsburg, Caroline, Md.			COUNTY			STATE					
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St.			ADDRESS Federalburg			25. DATE FCD. BY REGISTRAR 1982			26. DIRECTOR'S SIGNATURE Frampton-Hawkins Funeral Home											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3 RETAIN PAGE 1 FOR YOUR FILES. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

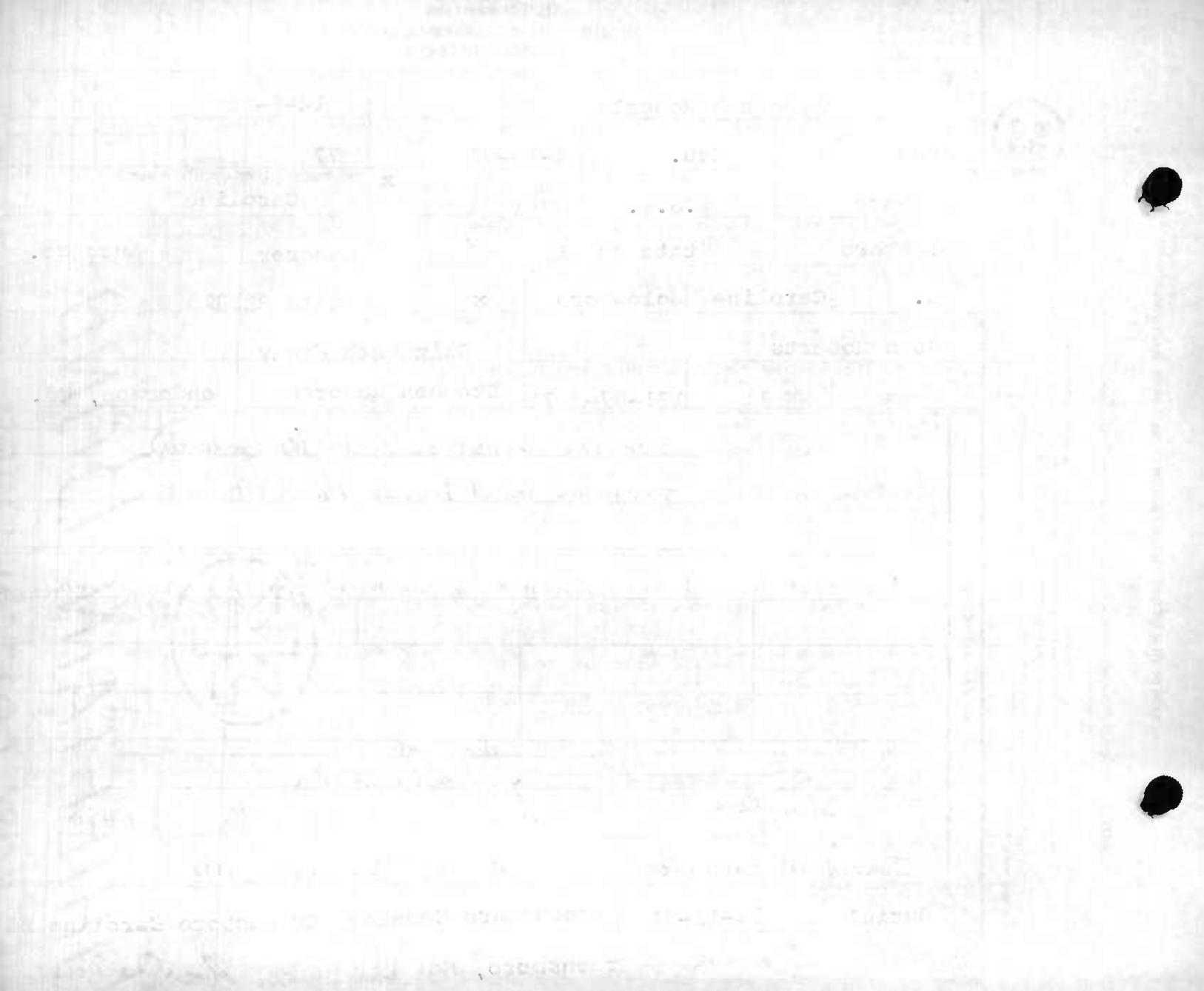
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												1 3 2 1 9 0							
1- FOR STATE REGISTRAR				REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF DEATH MATED				2b. HOUR							
Alethia C. Richardson								12 29 1981				M							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Female		Negro		Dec. 25, 1909		72 yrs.						12 29 1981		M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED				9. BALTIMORE CITY OR COUNTY OF DEATH							
Georgetown, S.C.				U.S.A.				<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED				Caroline							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Federalsburg				127 Smith Street				Food processor				King Cole							
13a. STATE Maryland				13c. CITY OR TOWN Caroline				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 127 Smith Street							
14. FATHER'S NAME FIRST Arthur T. Grant				15. MOTHER'S MAIDEN NAME FIRST Irene Hayward															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
No				248-07-6530				John Richardson, 127 Smith St., Maryland				Federalsburg,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												acute							
{ DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovasc dis												chronic							
(c)																			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). CARCINOMA OF PAN CREAS																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE Christian E. Jensen, M.D.												TITLE (SPECIFY) M.D. MEDICAL EXAMINER				DATE SIGNED		12/30/81	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				Denton, Maryland 21629											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORI				23d. LOCATION CITY OR TOWN							
Burial				Jan. 2, 1982				Federal Hill Cemetery				Federalsburg, Caroline, Md.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR REG. NO.											
Frampton-Hawkins Funeral Home, 216 N. Main St.								JAN 5 1982											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 3 2 1 9 1											
												REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Joseph Roberts												12-9-81						8 A M					
3. SEX			4 RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
male			Cau.			MONTH 3-10-04			DAY			YEAR			77		YRS		MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Hungary			U.S.A.									Caroline											
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY											
Goldsboro			State Rt 313			Laborer						Auto Co.											
13a. STATE Md.			13c. CITY OR TOWN Caroline			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS														
			Goldsboro						State Rt 313														
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST								
John Roberts									Elizabeth Nanay														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						ADDRESS											
yes			WW 11			131-07-0871			Stephen Roberts			Henderson, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest, suspected (sudden death)</u>																							
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Heart Disease, Atrial Fibrillation</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>12/9 1981</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>J. Shaffer</u>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>12/9/81</u>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY			STATE		
Joseph M Shaffer			Box 122 Goldsboro, Md.			Burial			12-11-81			Greensboro Cemetery			Greensboro			Caroline			Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
<u>John Henderson</u>			Greensboro, Md.			DEC 14 1981																	

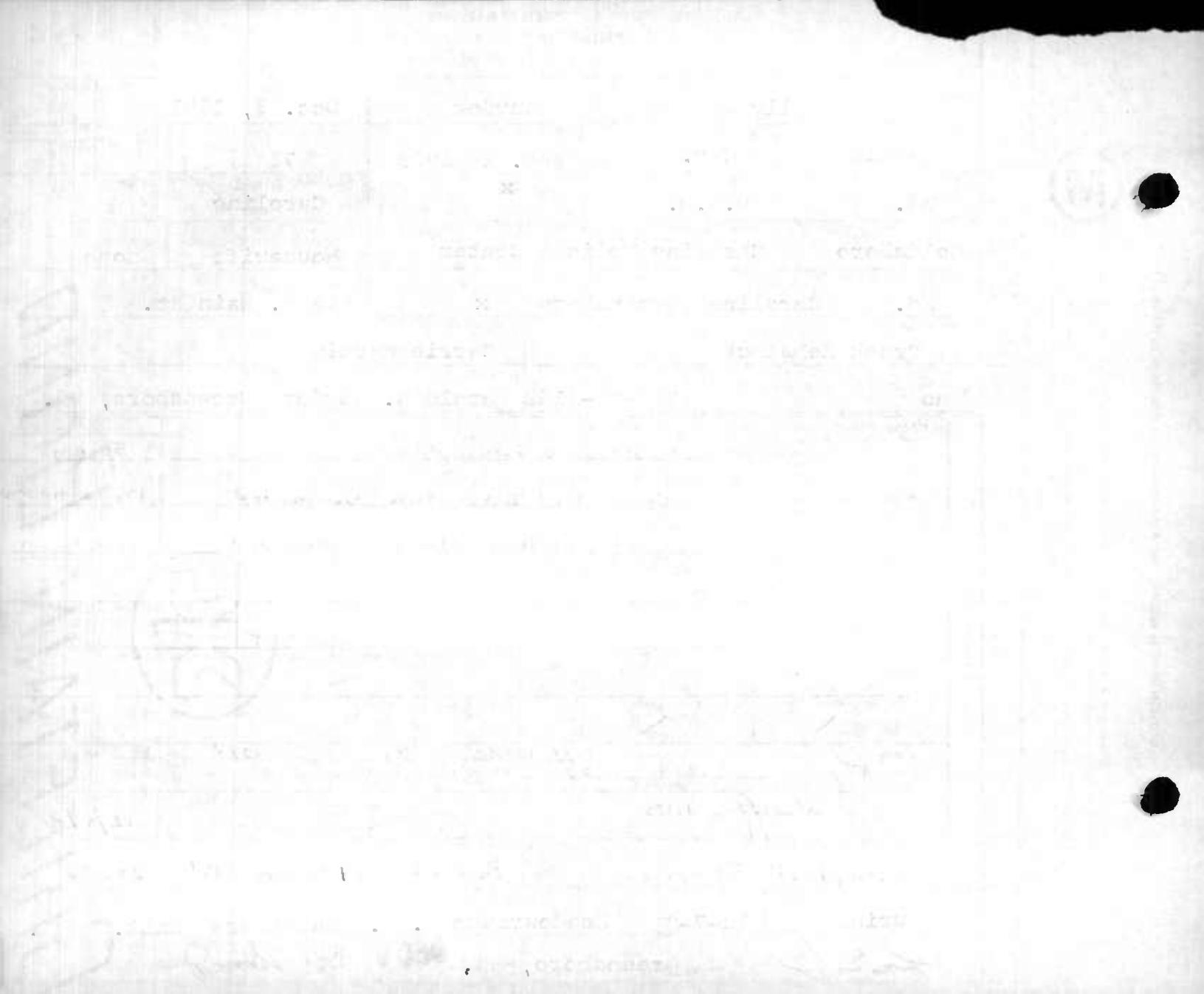


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 2 9 2			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			REG. NO.
Sally									Snyder			Dec. 3, 1981			
3. SEX female			4 RACE Cau.			5 DATE OF BIRTH MONTH Sept. DAY 24 YEAR 1909			6 AGE (IN YEARS LAST BIRTHDAY) 72			IF UNDER 1 YEAR YRS. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE COUNTRY Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Caroline			MD.			
10. CITY OR TOWN OF DEATH Goldsboro			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Caroline Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY none						
13a. STATE Md.			13b. COUNTY Caroline			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 113 N. Main St.						
14. FATHER'S NAME FIRST Frank Rebstock			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME Carrie Martin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 214-01-2162			17. INFORMANT Harold E. Snyder			ADDRESS Greensboro, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Ventricular Fibrillation</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 mins			
<u>4100</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction, suspected</u> DUE TO, OR AS A CONSEQUENCE OF												1 1/2 - 2 hours			
(c) <u>Ischemic Heart Disease, presumed.</u> DUE TO, OR AS A CONSEQUENCE OF												unknown			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension</u>															
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>12/3 10:30</u> , 19 <u>81</u> , to <u>12/3 19 81</u> , that (I) (we) last saw the deceased alive on <u>12/3 19 81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>J. Shaeffer MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>12/5/81</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph M. Shaeffer</u>			22e. ADDRESS <u>Box 122 Goldsboro, Md. 21636</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-7-81			23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge M. P.			23d. LOCATION CITY OR TOWN Baltimore Balt. Md.						
24. FUNERAL DIRECTOR NAME <u>John E. Boulton</u>			ADDRESS Greensboro, Md.			DATE REC'D. BY REGISTRAR <u>DEC 9 1981</u>			25b. REGISTRAR'S SIGNATURE <u>James J. Gant</u>						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY PAGES 1, 2, AND 3 ARE NEEDED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 11 per phone 1/4/82 dad STATE OF MARYLAND
FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE
1- STATE Item 6 G 563 1/19/82 PAR
REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 32193

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR			
Lester Elmer Swain						<input checked="" type="checkbox"/>	12-17	1981	3:45PM				
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS) AT BIRTHDAY	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. MONTH	DAY	YEAR	10. HOUR	
male	Cau.	6 03 1902				79	MONTHS	DAYS	HOURS	MIN	12-17	1981	7:50PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
DELAWARE		USA						Caroline MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Greensboro			in field while hunting					Restaurant Manager					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
DELAWARE		KENT		DOVER					14 SMALLWOOD DRIVE				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Elmer Swain					Swain	Mattie Riggs					Swain		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			222-14-6296			Betty Swain 14 Smallwood Dr. Dover							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> APPROXIMATE INTERVAL 4100 BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular disease</u> chronic (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Christian E. Jensen</u> TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) Christian E. Jensen MD ADDRESS Box 690, DENTON MD 21629 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORIAL Burial Dec. 20 1981 Odd Fellows 23d. LOCATION CITY OR TOWN Camden COUNTY Kent STATE Del.													
24. FUNERAL DIRECTOR NAME <u>John E. Boudis</u> ADDRESS <u>Greensboro</u> 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 24 1981 <u>James D. Walker</u>													
DHMH-17 (VR A15 ME(5)) 30M 7/73													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 3 2 1 9 4			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Alois						ZUEGER			12 6 81						4:50 P M
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR July 28, 1891			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 24 HRS		IF UNDER 24 HRS	
7a. BIRTHPLACE COUNTRY Switzerland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Caroline County			MONTHS		DAYS	
90 yrs.															
10. CITY OR TOWN OF DEATH Denton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Caroline Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Builder			12b. KIND OF BUSINESS OR INDUSTRY Boats						
13a. STATE Maryland			13b. COUNTY Caroline			13c. CITY OR TOWN Denton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Hobbs Road			
14. FATHER'S NAME FIRST MIDDLE LAST Alois Zueger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Furrer												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR RATES) 1920-21			17. INFORMANT Mrs. Margaret Zueger, Denton, Md.			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4850			Diseases of the heart and lungs			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)												
(c)			DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Arteriosclerosis, calcification of arteries															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 3/12/1881, 19 _____, to 12/16/1881, 19 _____, that (I) (we) last saw the deceased alive on 12/13/1881, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Philip P. Feipe, MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 14/1/81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip P. Feipe, MD			22e. ADDRESS 421 South Fifth Ave., Denton, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/8/81			23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cemetery			23d. LOCATION CITY OR TOWN Denton COUNTY Caroline STATE Md.						
24. FUNERAL DIRECTOR NAME MOORE FUNERAL HOME			ADDRESS DENTON			25a. DATE REC'D. BY REGISTRAR DEC 14 1981			25b. REGISTRAR'S SIGNATURE Anne Garrison						

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